PUB.15-1 (1993), and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.

~~b. All allowable capitalized costs included in (a) above plus all interest costs incurred as a result of financing the land, building, and equipment, including building equipment, major movable equipment, and minor equipment as described in HCFA PUB.15-1 (1993), shall be limited in total to the amount of interest cost that would be incurred if the land, building, and equipment had been financed through a "conventional financing" debt instrument over a 25-year period, with a 10 percent cash down payment, at an interest rate equal to the lesser of 15 percent or the prime rate plus 2 percent. In cases where the provider obtained greater than 90 percent financing, the difference between the actual down payment and a 10 percent cash down payment in this financing limit method shall be included with the balance sheet average equity for the period for purposes of computing an incremental change in return on equity or use allowance that would have occurred had a full 10 percent down payment actually been made. If the total ROE payment would increase from zero payment to a positive dollar amount, then the financing cost limitation on interest expense shall increase by that positive dollar amount. If the total ROE payment would increase from a positive payment to a greater amount, then the financing cost limitation on interest expense shall increase by the difference between the two amounts. For purposes of this provision, the "conventional financing" amortization schedule used shall provide for equal installments, that is, payments,~~

~~with amortization of the principal beginning in the first year, that is, a 25-year payout schedule. The prime rate used shall be the prime rate as stated by the Chase Manhattan Bank in New York as of: the date the provider received a loan commitment from the lending institution; or the date AHCA received the provider's acceptable budgeted cost proposal if no commitment date can be documented. Providers with variable rate debt instruments that are initially approved within these cost limitations shall be granted cost increases due to an increase in their interest rate, but not to exceed that cost which would be incurred at an interest rate of 15 percent per annum.~~

~~c. Additional costs due to refinancing shall not be allowed if refinancing was not necessary in order to meet the final payments of the former debt instrument, that is, in cases where balloon payments are due, or to finance the addition of new beds.~~

~~d. Providers currently enrolled in the Medicaid program as of June 30, 1984 and prospective providers who have already received firm written loan commitments as of June 30, 1984 shall not be subject to provisions (a) and (b) above.~~

~~e. AHCA shall make exceptions to the financing limitations set forth in (a) and (b) above when, in the judgment of the Office of Developmental Services, it is in the best interest of the State. Exceptions to the financing limitations shall be considered when it has been demonstrated through the Certificate of Need or Request for Proposal process that financing within the limitations of this plan is not available.~~

~~Should that decision be made, the HRS Office of Developmental Services shall issue a new Request for Proposal allowing other financing options. HRS shall reject any or all proposals which are~~

~~made in response to a new Request for Proposal if the department determines that the rejection is in the best interest of the State.~~

7. After June 30, 1984, additional costs incurred after enrollment in the program that are due to capital additions or expansion must have prior approval by the ~~HRS~~ DCF Office of Developmental Services if such costs exceed 1 percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's Certificate of Need process. Costs for specific expansion or additions that exceed the 1 percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in Section III.G.4. above.

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility after July 18, 1984, the actual cost of the improvements shall be added to the owner's basis, allowing the owner reimbursement of interest, return on equity, or both as specified in Section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider must maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

~~H. Return on equity~~

~~A reasonable return on equity capital (ROE) invested and used in providing resident care shall be defined for purposes of this plan as an allowable cost. This return on equity shall use the principles stated in Chapter 12, HCFA PUB.15-1 (1993), except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof~~

~~covered under the Medicaid program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis.~~

~~I.~~H. Use Allowance

A use allowance shall not be paid for publicly owned and publicly operated facilities. ~~on equity capital invested and used in providing resident care shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed only for non-profit providers, except for those facilities which are government-owned or operated. This use allowance shall use the principles established in Section H. above.~~

IV. Standards

A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs., ~~but historic costs shall be limited to allowable percentage increases from period to period, as described in L. below. Further, I~~if certain costs are determined by the AHCA Office of Medicaid or the AHCA Office of Audit Services, utilizing the Title XVIII Principles of Reimbursement, HCFA PUB.15-1 (1993) and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

C. Prospective payment rates shall be established semi-annually on April 1 and October 1. The most current acceptable cost report received by the agency by February 1 and August 1 shall be used in the rate-setting process to set rates effective on April 1 and October 1, respectively. The rate-setting process is detailed in Section V of this plan.

The same cost reports used for the April 1, 1991 rate semester shall be used to establish rates effective July 1, 1991 through March 31, 1992. There shall not be a rate semester for October 1, 1991.

D. Reimbursement rates shall be calculated separately for two classes. The classes shall be based on the four levels of ICF/MR-DD care as defined in Chapter ~~10C-7.049~~ 59G-4.170 of the Florida Administrative Code. The four levels of care, listed in ascending order of handicap severity, are Developmental Residential, Developmental Institutional, Developmental Non-ambulatory, and Developmental Medical. Developmental Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute the other. All providers must allocate costs by the four levels of care in their cost reports. The agency shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If the agency determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on four levels of care.

E. For the two classes described in D. above, ~~four~~ three components of the total reimbursement rate shall be calculated separately. These ~~four~~ three components are operating costs, resident care costs, property costs, ~~and return on equity costs or use allowance, if applicable.~~ Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rates.
2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The

amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.

3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process described in Section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections H. and I. below.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of 1 percent or more in the provider's total per diem reimbursement rate.

2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (l) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care,

operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Interim rate requests resulting from (l), (2), and (3) above must be submitted within 60 days after the costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously-established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement.

   Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider.

After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per Section I. below.

6. The right to request interim rates shall not be granted for fiscal periods that have ended.

H.~~1.~~ For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

A. Property Costs:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

B. Operating Costs:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

~~H.2. For a new provider in a facility with six beds or less, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited by ceilings as follows:~~

~~A. Property Costs Ceiling:~~

~~Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.~~

~~B. Operating Costs Ceiling:~~

~~Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.~~

~~C. Resident Care Costs Ceiling:~~

~~Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.~~

~~D.~~ ~~Total costs per diem ceiling (including return on equity):~~

~~Shall not exceed $174.17 for the Developmental Residential/Developmental Institutional classes and shall not exceed $194.56 for the Developmental Non-Ambulatory classes. For subsequent rate semesters, these ceiling amounts shall be inflated forward based on one times the ICF/MR-DD inflation index utilizing the same inflation methodology as used in calculating prospective rates. When a provider's interim cost is limited to the total cost ceiling, the ceiling shall be allocated to each component based on the percentage that each component's interim cost is to the total of all components' interim costs, including return on equity.~~

~~Example:~~	~~Interim Cost~~	~~Percent to total~~	~~Ceiling~~
~~Operating~~	~~46.52~~	~~23.26~~	~~43.73~~
~~Resident Care~~	~~127.11~~	~~63.56~~	~~119.48~~
~~Property~~	~~20.56~~	~~10.28~~	~~19.33~~
~~ROE~~	~~5.81~~	~~2.9~~	~~5.46~~
~~Total~~	~~200~~	~~100%~~	~~188~~

I.~~1.~~ For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total

allowable costs as determined by Medicaid and the Developmental Services Program Office.

~~I.2. For a new provider in a facility with six beds or less, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12-month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item subject to base year ceilings in Section V.C. of this plan shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs subject to base year ceilings in Section V.C. of this plan shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at the lesser of 100 percent of the total allowable costs or the ceilings as determined by Medicaid and the Developmental Services Program Office.~~

~~J. Incentives prior to July 1, 1991, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than the average cost increase for the applicable period documented by the ICF/MR-DD Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in Section V.B.7. of this plan.~~

~~1. To encourage high-quality care while containing costs, incentive payments and participation in costs that exceed target rates shall be paid to those facilities that receive a "favorable" licensure rating for the majority of days in the preceding rate semester by the Office of Licensure and Certification. No Medicaid incentive payments or participation in costs that exceed target rates as described in Sections V.B.7.(a) and (b) of this Plan shall be made to facilities with "non-favorable" licensure ratings, or to facilities that are not being paid prospective rates. Prior to the implementation of the system of quality measures, it will be assumed that each facility has a "favorable" licensure rating. When the system is implemented, it shall be assumed that~~